Notice of Rulemaking Hearing

Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

There will be a hearing before the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, to consider the promulgation of new rules pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-204, 50-6-102, 50-6-124, and 50-6-126. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204, and will take place in the Conference Room on the First Floor of the Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243 at 9:00 a.m. CDST on the 24th day of July, 2007.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Department of Labor and Workforce Development, Division of Workers' Compensation, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department's ADA Coordinator, Mr. Jewel Crawford, at Andrew Johnson Tower, 8th Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243-0655 and (615) 741-8805.

For a copy of the entire text of this notice of rulemaking hearing contact: E. Blaine Sprouse, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 532-8937.

Substance of Proposed Rules

Repeals

– Current Chapter 0800-02-06, Utilization Review, is hereby repealed in its entirety and is replaced with the following:

New Rules

Chapter 0800-02-06
Utilization Review

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0800-02-06-.01 Definitions

The following definitions are for the purpose of these Utilization Review Rules, Chapter 0800-02-06:

(1) "Act" means the Tennessee Workers' Compensation Act, T.C.A. §§ 50-6-101 et seq., as amended.

(2) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development, or the Administrator's designee.

(3) "Advisory Medical Practitioner" (also known as a "physician advisor") means a Tennessee-licensed practitioner in good standing, with the same or similar general specialty as the physician recommending a treatment, procedure, test or admission, who makes utilization review determinations for the utilization review agent.

(4) "Business day" means any day upon which the Workers' Compensation Division is open for business.

(5) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's Designee, or an agency member appointed by the Commissioner.

(6) "Contractor" means an independent utilization review organization not owned by or affiliated with any carrier authorized to write workers' compensation insurance in the state of Tennessee with which the Commissioner has contracted to provide utilization review for the Division, as referred to in T.C.A. § 50-6-124.

(7) "Day" means a calendar day, unless otherwise specifically designated in this Chapter.

(8) "Department" means the Tennessee Department of Labor and Workforce Development.

(9) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

(10) "Employer" means an employer as defined in T.C.A. § 50-6-102, but also includes an employer's insurer, self-insured employers, self-insured pools, and self-insured trusts.

(11) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in the relevant clinical areas and any other relevant factors.

(12) "Health care provider" means all of the following, including but not limited to, individuals or entities: licensed individual , chiropractor, physical therapist, physician, surgeon, group of practitioners, hospital, free standing surgical outpatient facility, health maintenance organization, industrial or other clinic, occupational healthcare center, home health agency, visiting nursing association, laboratory, medical supply company, community mental health center, and any other facility or entity providing treatment or health care services for a work-related injury

(13) "Independent medical examination" or "IME" means a physical examination and evaluation of the injured employee conducted by a practitioner different from the practitioner providing care pursuant to being chosen from the panel of practitioners required by T.C.A. § 50-6-204, a practitioner referred by the practitioner chosen from the panel of practitioners required by T.C.A. § 50-6-204, or any other practitioner recognized and authorized by the employer to treat any injured employee for a work-related injury.

(14) "Inpatient services" means services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds twenty-three (23) hours.

(15) "Medical Director" means the Medical Director of the Workers' Compensation Division appointed by the Commissioner of the Tennessee Department of Labor and Workforce Development pursuant to T.C.A. § 50-6-126, or the Medical Director's designee or a vendor chosen to act on behalf of the Medical Director by the Commissioner.

(16) "Medically-accepted standard" means either the current ACOEM or ODG Guidelines, which are hereby adopted by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

(17) "Medically necessary" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

(18) "Outpatient services" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers.

(19) "Practitioner" means a person currently licensed in good standing to practice as doctor of medicine or doctor of osteopathy.

(20) "Treating physician" means the practitioner chosen from the panel required by T.C.A. § 50-6-204, a practitioner referred to by the practitioner chosen from the panel required by T.C.A. § 50-6-204, or any other practitioner recognized and authorized by the employer to treat any injured employee for a work-related injury.

(21) "Utilization review" means the application of the medically-accepted standard adopted by the Division in evaluating the quantity or quality of health care or health care services in workers' compensation cases provided pursuant to the time deadlines, procedures, and requirements of this Chapter, 0800-02-06, and as defined in T.C.A. § 50-6-102.

(22) "Utilization review agent" means a business entity authorized to do business in Tennessee, registered with the state of Tennessee pursuant to T.C.A. § 56-6-704, that uses an Advisory Medical Practitioner with the same or similar general specialty as the physician recommending a treatment, procedure, or admission, to make all

utilization review decisions and contracts with the employer to provide utilization review services.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126.

0800-02-06-.02 Utilization Review System

(1) An employer may choose to provide utilization review services itself or through a third party administrator. Whenever utilization review is conducted, whether mandatory under this Chapter, 0800-02-06, or not, such utilization review shall be conducted in complete conformity with this Chapter. Failure to comply with this Chapter in any way may subject the employer to civil penalties as set forth in Rule 0800-02-06-.11.

(2) The Commissioner shall provide or contract for certain utilization review services. The state utilization review services provided or contracted for may include, but not be limited to, providing:

(a) A review of an individual case when a employee, employer, or health care provider, seeks an appeal;

(b) Review of utilization review services provided by other utilization review agents or firms for workers' compensation cases;

(c) Identification of health care providers who have rendered excessive or inappropriate services to the Commissioner for appropriate action; and

(d) Development of reports and summaries of utilization of medical care and services in workers' compensation cases in Tennessee or any political subdivision of the state.

(3) Any organization conducting utilization review for workers' compensation cases pursuant to this Chapter shall provide to the Administrator of the Division of Workers' Compensation copies of any information provided to the Commissioner of Commerce and Insurance pursuant to T.C.A. § 56-6-704 [Section 5(2) of Public Chapter 812].

(4) Subject to any applicable requirements of law concerning confidentiality of records, a utilization review agent shall provide the Commissioner or the Commissioner's designee with any appropriate utilization review records or permit the Commissioner or the Commissioner's designee to inspect, review, or copy such records in a reasonable manner.

(5) For utilization review purposes, the Division and its Contractor will maintain any required confidentiality of any personally identifying information concerning employees claiming workers' compensation benefits which the department may obtain. Provision of these records pursuant to this rule shall not constitute a waiver of an applicable privilege or confidentiality.

(6) Specific cases may be selected for review of utilization services review pursuant to the contract between the workers' compensation division and the contractor. The Contractor may attempt to contact the injured or disabled worker concerning the selection of his or her case for utilization review.

(7) The Contractor is specifically authorized to communicate directly with all health providers, any other utilization review organization involved, the employer, the injured

or disabled worker, and any representatives of the aforementioned interested parties for the purpose of implementing the Division's utilization review program. All parties shall cooperate and furnish all records, information and documentation to the best of their abilities in a timely manner, subject to civil penalties set forth in Rule 0800-02-06-.11 for violations, at the discretion of the Commissioner. The Contractor shall report all possible violations to the Administrator or the Commissioner.

(9) Any dispute concerning the reasonableness of any request for information may be submitted, in writing, to the Administrator. The determinations of the Administrator concerning the reasonableness of such requests are final. The Administrator may consult with the Medical Director in making such determinations.

(10) The worker's employer or third party administrator shall provide a copy of written utilization review reports to the Contractor.

(11) The Contractor or the employer's utilization review provider shall notify and make all written reports concerning utilization review available to the injured or disabled worker and his or her legal representative.

(12) All employers, employees, insurers, employer utilization review providers, health care providers and third party administrators of cases involving injured or disabled workers shall timely communicate and provide information to the Contractor for the purpose of facilitating utilization review. The health care providers, employer, insurer and/or third party administrator are required to cooperate and provide all information, without charge, to the Contractor.

(13) The Administrator may request and review any report or information provided to or prepared by the Contractor.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.03 Mandatory Utilization Review

(1) Utilization review shall be required and applied in all workers compensation cases requiring non-emergent inpatient services. All non-emergent inpatient cases shall be reviewed for medical necessity prior to admission. Additionally, utilization review is required in all instances in which it is mandated by the Tennessee Medical Fee Schedule Rules, Chapters 0800-2-17, 0800-2-18 and 0800-2-19.

(2) In emergency inpatient service situations, the facility shall notify the employer's utilization review agent within one (1) business day of admission to initiate utilization review.

(3) Utilization review shall be required in all workers' compensation cases whenever there is a dispute as to the appropriate medical treatment, testing or other medical services or when the injury results in cumulative outpatient services medical costs in excess of ten thousand dollars ($10,000).

(4) Utilization review shall not be required whenever a specific treatment, procedure, test or admission is expressly ordered by a court having proper jurisdiction or by a Workers' Compensation Specialist.

(5) The Advisory Medical Practioner shall determine the medical necessity, appropriateness and length of stay of a recommended treatment, procedure, or proposed admission.

Health care providers shall cooperate and timely furnish all information required by the utilization review agent concerning the recommended treatment, procedure, or proposed admission. The utilization review agent shall decide whether it has been provided all the necessary information required to make the utilization review determination. Any dispute concerning access to information shall be submitted to the Medical Director and the Medical Director's resolution shall be final and binding on the health care provider and utilization review agent for administrative purposes. Failure of any health care provider to cooperate and timely furnish all necessary information, records and documentation to a utilization review agent shall be a violation of these rules and may subject the health care provider to sanctions and/or civil penalties as set forth in this Chapter, 0800-02-06, at the discretion of the Commissioner.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126.

0800-02-06-.04 Hospital Pre-Admission Review

(1) Subject to requirements of T.C.A. § 56-6-705, with the exception of the appeal procedure set forth therein, which is replaced in workers' compensation cases by the appeal procedure set out in this Chapter, each employer or the employer's insurer covered by those rules shall establish and maintain a system of preadmission review of in-patient hospital care in non-emergency cases for employees claiming benefits under the Workers' Compensation Law. In non-emergency cases, planned or elective hospital admissions shall be reviewed for medical necessity prior to admission. In emergency cases, the hospital shall notify the employer's utilization review agent within one (1) working day of admission.

(2) Any health care provider ordering the admission of an injured or disabled worker for evaluation or treatment of his or her injury or occupational disease shall report to the employer's utilization review provider, at least forty-eight (48) hours prior to any overnight admission, all the information required by the Rule with regard to planned overnight admissions of injured or disabled workers.

(3) Any health care provider or hospital discharge planner ordering or arranging a transfer of an injured or disabled worker to another inpatient facility shall report to the employer's utilization review provider, at least twenty-four (24) hours prior to any transfer, all information required by this chapter with regard to planned overnight admission of injured or disabled workers; provided, however, that the hospital discharge planner, if any, shall be primarily responsible for satisfaction of this requirement.

(4) The employer's utilization review provider shall determine if it has been provided with all necessary information to render its decision concerning the necessity, appropriateness and length of stay of the proposed admission.

(5) If adequate information has been provided, the employer's utilization review provider shall:

(a) Render a decision concerning the necessity, appropriateness and length of stay of the proposed admission based upon medically accepted standards and an objective evaluation of the circumstances of the proposed admission;

(b) Verbally notify the hospital, payer and health care provider ordering the admission of its decision prior to the commencement of the proposed admission; and

(c) Transmit written notification to the hospital, payer and health care provider ordering the admission within twenty-four (24) hours of its decision.

(6) The health care provider, employer, insurer and third party administrator are specifically informed that, in the case of a compensable injury or disability, the employer, or its insurer, retains all financial responsibility for those health care services that are provided.

(7) If the employer's utilization review provider does not possess adequate information to render its decision prior to admission, the employer's utilization review provider shall verbally inform the hospital, health care provider and payer that it is unable to render a decision. The employer's utilization review provider shall, prior to the proposed admission, issue a written report to the hospital, health care provider, payer and Workers' Compensation Division of all failures to provide information that is adequate to allow it to render a decision.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.05 Emergency Hospital Admission Review

(1) Every hospital, as defined in T.C.A. § 68-11-201, shall provide to the employer's utilization review provider, before the close of business the next working day following any emergency overnight admission of an injured or disabled worker, all information required by this Chapter, 0800-02-06, and required for hospital planned/elective hospital admissions.

(2) Not later than the next working day, after information has been provided pursuant to this Chapter, the employer's utilization review provider shall provide a verbal certification or denial concerning the emergency overnight admission to the hospital, health care provider and payer with respect to the medical necessity of hospital services, diagnostic testing fees, treatments and procedures, the appropriateness of inpatient services, and the assigned length of stay, if any.

(3) The verbal certification or denial shall be confirmed in writing and transmitted by the employer's utilization review provider within twenty-four (24) hours of its decision.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.06 Inpatient Hospital Services.

(1) Throughout the period of time in which inpatient services are being provided to the injured or disabled worker, the employer's utilization review provider shall monitor the injured worker's condition, treatments, procedures and length of stay for medical necessity and appropriateness. All health care providers, as defined in Rule 0800-02-06-.01, are required to cooperate with the Contractor and employer's utilization review provider for concurrent review of hospitalization and are required to provide, without additional charge to any party, any available medical information requested by the Contractor or employer's utilization review provider for that purpose. Any dispute concerning the reasonableness of the request for information by the employer's utilization review provider or Contractor for purposes of concurrent review shall be determined by the Administrator upon the written request of any party. All determinations of the Administrator pursuant to this Chapter shall be final.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.07 Outpatient Review

(1) Each employer shall establish and maintain a system of utilization review of outpatient medical care in outpatient cases involving employees claiming benefits under the Workers' Compensation Law.

(2) Utilization review shall be applied to all outpatient cases involving employees claiming benefits under the Act whenever:

(a) The injury results in cumulative medical costs in excess of ten thousand dollars ($10,000);

(b) There is a dispute as to the appropriate medical treatment, testing or other medical services.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.08 Utilization Review Requirements

(1) In any case in which utilization review is undertaken, the utilization review agent shall make an objective evaluation of the recommended treatment, procedure, or proposed admission and render a determination concerning the medical necessity, appropriateness, and/or length of stay of the recommended treatment, procedure, and/or proposed admission based upon the medically accepted standard adopted by the Division. In no event shall utilization review ever consider causation of an injury, that is, whether the injury is work-related, as this is not a part of the utilization review process.

(2) Utilization review agents shall only use the specific medically-accepted standards adopted by the Division as described in Rule 0800-02-06-.01(16) above, the current AOECM or ODG Guidelines. Failure to do so shall render any utilization review determination completely invalid and may subject the employer to the civil penalties set out in this Chapter.

(3) The utilization review agent shall produce a written report which renders the determination on the medical necessity, appropriateness, and length of stay for the recommended treatment, procedure, or proposed admission. Inclusion of any statement relating to causation or the work-relatedness of an injury shall be a violation of this Rule and shall subject the employer and the utilization review agent to civil penalties. All such statements shall be stricken from any report immediately. If the determination concludes that the recommended treatment, procedure, or proposed admission is not medically necessary or appropriate, the utilization review agent must include the principal reason or ground for the determination. All written reports must include the appeal information and procedures set out in Rule 0800-02-06-.10, Appeals of Certification Decisions. The utilization agent shall transmit the written report to the health care provider recommending the treatment, procedure, or proposed admission, the injured employee, any legal representative of the employee and the employer.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126.

0800-02-06-.09 Time Requirements

(1) If a recommended treatment, procedure, or proposed admission requires utilization review, an employer shall send the case to the utilization review agent within three (3) business days of issuance of notification by the health care provider of the

recommended treatment, procedure, or proposed admission. If the employer fails to send a mandatory case for utilization review within three (3) business days of such notice, the recommended treatment, procedure, or proposed admission is deemed approved and the employer may be subject to civil penalties pursuant to this Chapter, 0800-02-06. The approval pursuant to this paragraph is final and binding on the health care provider, injured employee, and employer for administrative purposes.

(2) The utilization review agent shall render the determination, produce a written report, and transmit the report to the recommending health care provider, the injured employee and employer within two (2) business days of receipt of the case from the employer. If the utilization review agents fails to render a determination, produce the written report, or transmit the written report to the health care provider, injured employee, and employer within such (2) business days, the recommended treatment, procedure, or proposed admission is deemed approved and the employer may be subject to civil penalties. The approval pursuant to this paragraph is final and binding on the health care provider, injured employee, and employer for administrative purposes.

(3) The employer must communicate authorization or denial to the employee, any legal representative of the employee, and the health care provider within three (3) business days of the employer's receipt of the utilization review determination. If the employer fails to communicate authorization or denial to the employee, any legal representative of the employee, and health care provider within (3) business days, the recommended treatment, procedure, or proposed admission is deemed approved and the employer may be subject to civil penalties. The approval pursuant to this paragraph is final and binding on the health care provider, injured employee, and employer for administrative purposes.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.10 Appeals of Certification Decisions

(1) Any party aggrieved by a decision of an employer's utilization review agent concerning pre-admission, or outpatient or inpatient review certifications, may request an appeal of the decision in writing to the Division's Utilization Review Contractor. Within five (5) business days after communication from the employer to the health care provider, the injured employee, and any legal representative of the employee of any denial, the employee or health care provider may request review of the utilization review determination directly to the Division's Contractor. The Contractor shall charge a fee for this independent utilization review appeal which shall be a reasonable fee as determined by the Commissioner. The employer shall be responsible for paying this fee directly to the Contractor. The Contractor shall consider the matter as an expedited appeal and shall render a determination within five (5) business days after the appeal is filed with the Contractor. The Contractor shall communicate its determination to the health care provider, injured employee, any legal representative of the employee and the employer. The determination of the Contractor is final and binding on the health care provider, injured employee, and employer for administrative purposes.

(2) The employer must communicate authorization or denial of any proposed treatment, test, procedure, or admission to the employee, any legal representative of the employee, and the health care provider within three (3) business days of the employer's receipt of the utilization review determination. If the employer fails to communicate authorization or denial to the employee, any legal representative of the employee, and health care provider within (3) business days, the recommended treatment, test, procedure, or proposed admission is deemed approved and the employer may be subject to civil

penalties as prescribed in this Chapter. The approval pursuant to this paragraph is final and binding on the health care provider, injured employee, and employer for administrative purposes.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126.

0800-02-06-.11 Excessive or Inappropriate Utilization

(1) The Commissioner may find that a health care provider has rendered excessive or inappropriate services or care when the services or care were not medically necessary or justified.

(2) If the Commissioner finds that any health care provider has rendered inappropriate services, the Commissioner may proceed in accordance with Rules 0800-02-06-.11, and Rule 0800-02-06-.12; provided, however, that if the excessive or inappropriate services have been explicitly ordered by another health care provider, the ordering health care provider shall be held primarily responsible by the Commissioner.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.12 Sanctions and Penalties

(1) Failure by an employer, third party administrator, or health care provider to comply with any requirement in this Chapter, 0800-02-06, including but not limited to applying utilization review when required and complying with time deadlines for utilization review, shall subject such party to a penalty of not less then one hundred dollars ($100.00) nor more than one thousand dollars ($1,000.00) per violation.

(2) If, after consultation with the Medical Director, the Commissioner finds that a provider has rendered excessive or inappropriate services, the Commissioner shall give notice of such finding with a recommended sanction to the provider pursuant to Rule 0800-02-06-.10. If the provider desires to contest an order of the Commissioner imposing the sanction or civil penalty, then Rule 0800-02-06-.11 shall apply.

(3) Pursuant to the utilization review conducted by the Commissioner, including providing an opportunity for a hearing, any health care provider who is found by the Commissioner to have rendered excessive or inappropriate services may be subject to:

(a) A forfeiture of the right to payment for those services that are found to be excessive or inappropriate;

(b) A civil penalty of not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000); or

(c) A temporary or permanent suspension of the right to provide medical care services for workers' compensation claims, if the health care provider has established a pattern of violations.

(4) A forfeiture pursuant to subparagraph (3)(a) of this Rule shall be a sanction in addition to any action that an employer or insurer might undertake pursuant to contract or law. Any sanction imposed by this rule is in addition to any other sanction or action permitted by contract or law.

(5) Any party aggrieved by the assessment of sanctions and/or civil penalties pursuant to this Chapter, 0800-02-06, shall have the right to a contested case hearing and appeal

within the Department pursuant to the Uniform Administrative Procedures Act, T.C.A §§ 4-5-101 et seq. The Department is authorized to conduct the hearing pursuant to T.C.A § 50-6-118.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

0800-02-06-.13 Issuance and Appeal of Sanction and Civil Penalty Assessment Orders

(1) An order assessing civil penalties or other sanctions shall be mailed to the party to whom the order is issued, and the party to whom it is issued shall have fifteen (15) days from the date of issuance of the order to either appeal the Commissioner's order pursuant to the procedures provided for under Tennessee's Administrative Procedures Act, T.C.A. §4-5-101, et seq., or to pay the assessed penalties to the Department or otherwise comply with the order.

(2) In order for a party to appeal an order issued by the Commissioner assessing civil penalties or sanctions, the party must file a petition with the Commissioner within fifteen (15) days of the issuance of the order. This petition shall be considered a request for a contested case hearing pursuant to the Uniform Administrative Procedures Act, T.C.A. § 4-5-101, et seq.

(3) If the Commissioner's order assessing civil penalties or sanctions is not appealed within fifteen (15) days of its issuance by the provider, the order shall become a final order of the Department.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126.

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of May, 2007. (FS 05-19-07, DBID 637)